Newborn Screening Program
GENETIC DISEASE BRANCH
DEPARTMENT OF HEALTH SERVICES
2151 Berkeley Way, Annex 4, Berkeley, CA 94704-1011
(510) 540-2000

Itemized Bill for Newborn Screening

Amount Due: **$41.00**
Date Due: 04/01/2002
Account #:
Statement Date: 03/02/2002
GDB Federal Tax ID # 94-3402381

Referring Physician

PRIVACY STATEMENT

DHS 4477 (9/01)

The Information Practices Act of 1977 (Civil Code 1798 et. seq.) requires that the State describe the procedures used to collect and safeguard private, confidential information.

The Department of Health Services, Genetic Disease Branch, maintains any information supplied in response to this document. It will be used to bill insurers and apply payments. Submission of information is voluntary and is not required by law. Failure to provide the information could prevent the Department from billing your insurer. All information procured by the Department, or by any person, agency, or organization acting jointly with the Department, shall be confidential. Access to these records is regulated under the provision of Article 8 of the Civil Code.

Date of Service	Service Code	Description of Services	Amount Billed	Insurance Paid	Patient Paid	Adjustments	Patient Balance
07/23/2001	84030	PHENYLALANINE	4.00	0.00	0.00	0.00	4.00
07/23/2001	84510	TYROSINE	12.00	0.00	0.00	0.00	12.00
07/23/2001	82776	TRANSFERASE	5.00	0.00	0.00	0.00	5.00
07/23/2001	84443	THYROID STIMULATING HORMONE	10.00	0.00	0.00	0.00	10.00
07/23/2001	83021	HEMOGLOBIN CHROMATOGRAPHY	10.00	0.00	0.00	0.00	10.00
Diagnosis code: V77.3		Total	41.00	0.00	0.00	0.00	41.00

Important Message Regarding Your Account

PAYMENT DUE IN 30 DAYS.
If you have insurance coverage for this test, complete the enclosed Insurance Information Form and return it in the enclosed envelope.

▼ DETACH THIS STUB AND RETURN WITH PAYMENT OR MEDI-CAL INFORMATION IN THE ENCLOSED ENVELOPE ▼

State of California - Health and Human Services Agency
Department of Health Services

Amount Enclosed: $ _____
Make checks payable to: Genetic Disease Branch

Itemized Bill for Newborn Screening

Amount Due: **$41.00**
Date Due: 04/01/2002
Account #:
Statement Date: 03/02/2002
GDB Federal Tax ID # 94-3402381

Medi-Cal Information

Date of Birth: _____/_____/_____

CA Benefits ID Card #: _____

I authorize the release of any medical or other information necessary to process this insurance claim & assign payment of medical benefits to the Genetic Disease Branch of the Department of Health Services for services rendered. I understand & agree that I am responsible for payment.

_____ _____
Signature of Patient/Insured or Authorized Person Date

Credit Card Payment

[ ] VISA [ ] MasterCard Amount Charged: $_____

Card Number: _____
Cardholder's Name: _____
Cardholder's Address: _____
_____
PRINT

Expiration Date: _____/_____

_____
Cardholder's Signature

1708221052 041005